



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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September 15, 2006

Denise Buckner, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864

Provider #: 135055

Dear Ms. Otto:

On **August 23, 2006**, a Complaint Investigation was conducted at Valley Vista Care Center of Sandpoint. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001493

ALLEGATION #1:

The complainant indicated the facility had poor staffing. The facility recently went to 12 hour shifts from 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. In the part of the facility known as the Village they have 35-37 residents. Fifteen of these residents require a Hoyer or two person lift. Prior to the 12 hour shifts they had three certified nursing assistants (CNAs) on each shift. Currently they have two CNAs, with one Restorative nursing assistant (RNA) who is supposed to work 4:00-9:00 p.m. The RNA has missed several days of work recently and there was no one to cover for the RNA. They no longer have a bath aide in the evenings and it is expected that four baths be given each night. On Sunday night, June 11, 2006, two residents eloped from the building. The complainant only identified one of the residents. On several nights, some residents are still up at 10:00 p.m. because they do not have enough staff to put them to bed before then. Call lights ring for long periods of time. They start getting residents up at 5:00 a.m. If a resident wakes up and asks, "Is it time to get up?" staff is to get them up.

FINDINGS:

The facility's as worked staffing schedules were reviewed for the time frame identified in the complaint. The facility met and exceeded the required hours of staffing for each day. There was documentation of an RNA on duty for each of the days reviewed. The facility is not required to have a bath aide.

All accident and incident reports were reviewed for elopements. The one resident who was named had no incident report. The nurses' progress notes documented the resident was out by the Cottage door sitting in his wheelchair on the date specified in the complaint. The nurse who wrote the note was interviewed. The nurse indicated that the resident was not outside, but out of his room and by the entrance door to the Cottage (a closed unit) next to nurses' station. The outside patio area was observed and was completely fenced in with a gate that was locked. Residents who used the patio were still on facility's property and did not have access to outside of the gate.

It could not be determined by the interviews of several residents that they were being forced to stay up any longer than they wanted to. Staff interviewed, did not indicate this was a practice of the facility. In addition, the survey team entered unannounced at approximately 5:10 a.m. Three residents were up in the Village Unit. One of the residents stated she always gets up early. The other two residents were not observed to be affected by getting up early. Staff interviewed stated the residents wanted to get up when they woke up and this was a routine for these residents. One resident was up on the Cottage unit. The resident wanted to be up and was watching TV. One resident was up on the other closed unit. He indicated he wanted to be up and was drinking coffee and watching TV. The surveyors did not find any staff or residents who substantiated this portion of the complaint.

The call lights did not go unanswered for long periods of time when observed by the surveyors.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident developed a stage two pressure ulcer on her buttock because she was not being repositioned.

FINDINGS:

The identified resident's record was reviewed. The resident developed a 1 x 1 centimeter partial thickness skin loss to her right coccyx. The site was assessed and treated appropriately and the wound healed within ten days. Her care plan identified she was to be repositioned frequently while in bed. Staff was interviewed and they stated the resident is being repositioned as care

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planned. The resident cannot reposition herself but often moves enough in bed to cause some friction to her buttock region. A certified wound care nurse consults in the facility two to three times a week and monitors the residents' pressure ulcer prevention and treatment plans as needed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script that reads "Marcia Key for". The signature is written in dark ink and is positioned above the printed name of the signatory.

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj



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On **August 23, 2006**, a Complaint Investigation was conducted at Valley Vista Care Center of Sandpoint. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001495

ALLEGATION #1:

The complainant stated staff were getting residents up and dressed at 4:00 a.m. In addition, residents were getting up and into their wheelchairs for dinner by 4:00 p.m. These residents were then put to bed between 10:00 - 11:00 p.m. On June 11, 2006, at 10:30 p.m., nine unidentified residents were observed sitting in their wheelchairs at the nurses' station crying for help and wanting to be put to bed. On June 10, 2006, a resident, last name unknown, was placed in her room sitting in her wheelchair after dinner. She was not found until 11:00 p.m.

FINDINGS:

The surveyors entered the building at approximately 5:10 a.m. Three residents were up in the Village Unit. One of the residents stated she always gets up early. The other two residents (unable to interview) were not observed to be affected by getting up early. Staff interviewed stated the residents wanted to get up when they woke up and this was a routine for them. One resident was up on the Cottage unit. The resident wanted to be up and was watching TV. One resident was up on the other closed unit. He indicated he wanted to be up and was drinking coffee and watching TV. It could not be determined by interviews of several residents that they

were being forced to stay up any longer than they wanted to. Staff interviewed, did not indicate this was a practice of the facility. It was not unreasonable to get residents up by 4:00 p.m., as this is close to the dinner hour. Nine residents could not be named by the complainant. It was not possible to determine who the residents were or if the residents were up at 10:30 p.m., by choice or because they were not helped to go to bed. The surveyors did not find any staff or residents who substantiated this portion of the complaint.

The complainant gave a first name (a nick name) only regarding a woman who was found sitting in her wheelchair in her room at 11:00 p.m. The surveyor spoke with two residents who may have used that name and did not receive information from either regarding this incident. The surveyor asked staff if they ever had a resident in the facility who went by the name given by the complainant. The staff indicated they had a resident who had expired that had used the name. The resident's closed record was reviewed. There was no documentation to support the allegation that she had been left in her room until 11:00 p.m. The facility incident and grievance reports were reviewed and did not reveal documentation of the incident described. Several staff was interviewed and did not recall the incident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd for".

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj



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Provider #: 135055

Dear Ms. Otto:

On **August 23, 2006**, a Complaint Investigation was conducted at Valley Vista Care Center of Sandpoint. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001706

ALLEGATION #1:

The complainant stated an identified resident has had frequent nosebleeds and when the resident was visited recently there was dried blood on the resident's bed. A black floor mat was in the resident's bathroom in front of the toilet. The mat was "soaked in urine." There were also urine soaked floor mats in rooms #307, #312 and another room on the 300 hall, room number unknown. The complainant stated the facility was made aware of both of the above issues, however, nothing was done.

FINDINGS:

On August 23, 2006, at 5:15 a.m. a tour of the facility and residents' rooms was conducted to include the rooms on the 300 hall. Each room observed was neat and without offensive odors. There were no mats on any of the bathroom floors. None of the floors appeared to be wet. There was no resident room #312 in the facility.

Random residents were interviewed. They indicated there were no housekeeping concerns. The Resident Council minutes and grievance reports were reviewed for the previous three months.

There were no housekeeping concerns.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant was concerned about the resident's pain. She stated the resident was admitted to the facility a couple of months ago following an appendectomy. She stated she talked to the resident over the phone on August 13, 2006, and the resident told her she was "doubled over in pain," located in her abdominal area. The complainant stated the resident has been receiving Morphine but it was not effective. The complainant was concerned about the surgical incision site. She stated she talked to the Director of Nursing (DON) and was informed that they were aware of the situation but nothing could be done about it.

The complainant also was concerned about the resident's frequent nosebleeds as the resident has been on Coumadin. The complainant talked to the DON about this as well and asked if any laboratory work could be done. The complainant stated the DON indicated that laboratory work could not be done. No reason was given.

FINDINGS:

The resident was in the facility from July 11 to August 14, 2006. Her medication administration record and nurses' notes were reviewed. The resident developed chest pain on July 15, 2006, and she was sent to the emergency room for evaluation. She was not admitted to the hospital.

The resident's abdominal discomfort was documented as being well controlled with Tylenol from July 17 to July 24, 2006. On that day she experienced an increase in her abdominal pain. The physician was notified and an order was received for Morphine. The record documented she received good pain control on a minimum dosage of morphine from July 27 through August 13, 2006. On August 14, she started to experience an increase in pain and required the Morphine three times. At 3:00 a.m. the nurse spoke to the physician who, according to the documentation, determined the resident did not require hospitalization at that time. At 6:35 a.m. the physician was again notified of the resident's condition and an order was received to transport the resident to the hospital.

The record also documented the facility faxed a report to the physician on July 24, 2006, which addressed the resident's increased abdominal pain and a new finding of drainage on the abdominal dressing. The physician returned the fax and documented the resident would be assessed the following day. The physician's progress note, dated July 26, 2006, identified a "minor wound infection." There was no physician's order for an antibiotic.

The resident's admission history and physical report by the treating physician did not identify that

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the resident had a problem with nosebleeds. She had been on Coumadin in the past; however, at the time of her admission and throughout her stay in the facility she was not receiving Coumadin. The remainder of the record also did not document any concerns about nosebleeds.

The interim DON was interviewed. She stated that on or about August 13, 2006, she observed the resident picking her nose which caused it to slightly bleed. A family member was in the room at the time. The DON instructed the resident to not pick her nose. There were a few small drops of fresh blood on the pillowcase. The DON stated she had asked another nurse at that time if the resident had, at any previous time, picked her nose causing it to bleed. The nurse reported to her she had seen the resident pick her nose causing only minimal bleeding.

There was no documented evidence the resident sustained nosebleeds which required medical intervention.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script, appearing to read "Marcia Key", followed by the word "for".

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj